Arizona
HUMAN RESOURCES

Benefits Enrollment Guide

University Employees • 2006-2007

Benefit Options
Choice. Value. Health.

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INTRODUCTION

In this valuable reference guide, we have included explanations of the benefit programs, important plan information, contact addresses, phone numbers, web addresses, and comparison charts. This document is no longer just an enrollment guide, it is a resource to use throughout the year for services and benefits provided to you as a university employee. In this guide, you will find the information you need to make informed decisions regarding the selection and continued management of your benefits.

How to Use This Guide

The Benefits Enrollment Guide is divided into chapters, each covering a specific benefit program or important information. These programs include:

- Employee Wellness
- Medical Plans
- Pharmacy Benefits
- Dental Plans
- Vision Plans
- Basic, Supplemental and Dependent Life Insurance
- Disability Plans
- Flexible Spending Accounts
- COBRA
- Additional Benefits

It is very important that you review this guide so you can fully understand the benefit programs offered to you through the State of Arizona and your university. Of all the benefits available to you as an eligible employee, these benefit programs may be the most valuable. These programs offer a variety of plans and coverage options. This is your opportunity to select the coverage appropriate for both you and your qualified dependents.

You must make your initial enrollment selections within 31 days of your date of hire (or eligibility date for newly benefits-eligible employees). If you fail to enroll within the 31-day enrollment period, you waive your right to enroll in these plans until the next Open Enrollment or until you have a Qualified Life Event.

During your initial benefits enrollment, you may take the following actions:

- Elect or decline medical, dental and/or vision plan(s) for yourself and qualified dependents
- Elect or decline supplemental life insurance for yourself
- Elect or decline life insurance for your qualified dependents
- Elect or decline short-term disability (STD)
- Elect or decline to participate in the Flexible Spending Account (FSA) plans

Enrollment Facts

- New employees and newly benefits-eligible employees must enroll within 31 days of the date of hire/benefits eligibility.
- Medical, dental, vision, supplemental life, STD and Flexible Spending Account plans become effective on the first of the month following the date of enrollment.
- Basic life insurance and long-term disability are effective the date of hire/benefits eligibility.

The Benefits Enrollment Guide is designed to provide an overview of the Benefit Options Program. The actual benefits available to you and the descriptions of these benefits are governed by the relevant summary plan descriptions and contracts. The State of Arizona reserves the right to modify, change, revise, amend or terminate these benefit plans at any time.

CONTACT INFORMATION CHART

Contact	Phone Number	Web Address	Policy Number
Medical Plans			
Fiserv Health - Harrington (for Arizona Foundation, Beech Street, RAN+AMN, Schaller Anderson)	1.888.999.1459	www.myazhealth.com	3J
TDD/TTY	1.866.503.3463		
UnitedHealthcare	1.800.896.1067	www.myuhc.com	705963
TDD/TTY	1.888.697.9055		
BlueCross BlueShield (NAU only)	1.800.423.6484	www.bcbsaz.com	Grp #0002 Active
Pharmacy			
Walgreens Health Initiatives	1.866.722.2141	www.mywhi.com	512298
Dental Plans			
Assurant	1.800.443.2995	https://www.assurantemployeebenefits.com	EA82
Delta Dental	1.800.352.6132	www.deltadentalaz.com	7777-0000
Employers Dental Services	1.800.722.9772	www.mydentalplan.net	6300
MetLife Dental	1.800.942.0854	www.metlife.com/dental	94739
Vision Plan			
Avesis, Inc.	1.800.828.9341	www.avesis.com	10790-1040
Flexible Spending Accounts			
ASI	1.800.659.3035	www.asiflex.com	
Life Insurance Plans			
Standard Insurance Company	1.866.440.4846	www.standard.com/mybenefits/arizona/	617950
Aetna Life Insurance	1.800.523.5065	www.aetna.com	
Short Term Disability			
Standard Insurance Company	1.866.440.4846	www.standard.com/mybenefits/arizona/	
UnumProvident	1.800.237.7736	www.unumprovident.com	
Travel Assistance			
MEDEX	1.800.527.0218	www.standard.com/eforms/12092w.pdf	7088
Other Important Numbers			
Arizona State University Tempe: PO Box 875612 Tempe AZ 85287 West: PO Box 37100 Phoenix AZ 85069 Polytechnic: 7001 E. Williams Field Rd Mesa AZ 85212	480.965.2701 602.543.8400 480.727.1085	www.asu.edu/hr/benefits www.west.asu.edu/hr/hr.html	
Northern Arizona University PO Box 4113 Flagstaff, AZ 86011-4113	928.523.2223	www.hr.nau.edu/m/ email: hrcontact@nau.edu	
The University of Arizona 888 N Euclid, Ste. 114 Tucson, AZ 85721	520.621.3662	www.hr.arizona.edu email: benefits@email.arizona.edu	
ADOA Benefits Office 100 N 15th Ave #103 Phoenix, AZ 85007	602.542.5008 or 1.800.304.3687	www.benefitoptions.az.gov email: azboquestions@azdoa.gov	

EMPLOYEE WELLNESS

The benefits packages offered by all three state universities provide for the fact that you don't check your life at the door when you come to work. Family illnesses, finding care for an aging parent and relationship conflict are examples of how life can occasionally get out of balance with work.

Employee Assistance programs that are confidential and free are available to help employees sort things out, make changes and get referrals as needed. Worksite wellness programs can help employees reduce their risks for health problems and enhance their well-being. Governor Janet Napolitano has made employee wellness a priority for the State of Arizona.

At Arizona State University, Health Watch, the ASU Employee Wellness Program is designed to identify and deliver high quality, practical health education programs and screening services to promote and support ASU employees in establishing and maintaining healthy lifestyles. Screening services include cholesterol, diabetes, osteoporosis, skin cancer, thyroid, PSA, and mammography. All screenings include professional consultation and referrals if needed. Classes focus on nutrition, stress management, exercise and a variety of general health education topics. Additional activities include a flu prevention program, weight management program, and smoking cessation program.

The Work/Life Program at ASU is designed to be a strong, supportive culture for employees that is dynamic, flexible and respectful of the whole person. A sense of well-being crosses four domains of employees' lives: physical, mental, spiritual and emotional. When work/life programs can affect several or all of these in a positive manner, they contribute to healthier more productive employees. Program services include credit counseling/money management assistance, housing assistance, pre-paid legal services, and lawyer referral services. Discount coupons and tickets are available for over 50 attractions in Arizona, California, Florida, Texas, Colorado, Pennsylvania, and Virginia. In addition, over 150 businesses representing a wide range of goods and services extend ASU employees discounts.

At The University of Arizona, Life & Work Connections is a unique program that integrates Employee Assistance and Worksite Wellness together with Child Care and Family Resources, Elder Care and Life-Cycle Resources, and Work/Life Support. A variety of activities and educational presentations have been developed from a "whole-person, life-cycle" point of view to help employees make small lifestyle changes that increase resiliency and overall health and well-being.

Wellness screenings feature in-depth heart health risk assessment, diabetes, osteoporosis and skin cancer screenings all of which include on-site master's and Ph.D. level consultation and, if needed, referrals. A flu prevention program, weight management, nutrition and fitness consultations, a walking program, and smoking cessation program referrals are included also. Department specific requests for a range of educational presentations on topics that cover health, family, professional and personal development can also be arranged. Our services can be viewed at http://lifework.arizona.edu and are offered not only to help you cope with emergencies, but also to help you plan for balance in your life and work.

At Northern Arizona University, the Employee Assistance and Wellness (EAW) office is designed to provide opportunities to enhance individual and organizational well-being. The EAW office blends the services of Employee Assistance with Worksite Wellness to help faculty, staff and their families strengthen their overall health and wellness. The EAW office focuses on "the whole person" viewing wellness as a proactive process of moving toward optimal health - based on each individual's needs and readiness for change. A variety of services are offered to help members of our employee community address personal and professional issues, assist with life and work balance, and enhance optimal health and well-being.

EAW services include:

The Wellness at Work Program offers **flu vaccines** and **health screenings**. Health screenings focus on early detection and prevention of heart disease and diabetes. Additional screenings offered include mammograms and skin cancer screenings. This program is co-sponsored with the NAU Fronske Health Center.

The Wellness Workshop Series offers a wide range of seminars and activity classes focused on health, nutrition, family, relationships, and personal and professional growth.

Customized workshops are developed on request for departments and groups. Topics include: team development, communication, healthy work climates, and managing stress.

Short-term counseling and consultation is offered for work-related and personal issues.

Critical incident response services are available for personal and work-related emergencies during the work day.

Conflict management services assist in facilitating communication between two or more people in the workplace.

Information and referrals are provided to campus and community resources.

Additional information about EAW can be found on our website at http://www4.nau.edu/eaw/. Our office is located at 415 S. Beaver Street, Flagstaff, AZ 86001. You can contact us by phone at 928.523.1552 or by email at Ask-EAW@nau.edu.

ELIGIBILITY

Eligible Employees

University employees regularly scheduled to work 20 hours or more per week for six months or longer (except those listed below as ineligible) and their qualified dependents may participate in the Benefit Options and University Benefits Programs and FSA plans, provided they comply with the contractual requirements of their selected plans.

Ineligible Employees

- Employees who work less than 20 hours per week
- Employees in seasonal, temporary or emergency positions
- Employees in university graduate assistant/associate positions
- Patients or inmates employed in state institutions
- Non-State employee officers and enlisted personnel of the National Guard of Arizona
- Employees in positions established for rehabilitation purposes
- Student and work study employees

Eligible Dependents

- Your legal spouse
- Natural, adopted and/or stepchildren unmarried and under age 19, or under 25 if a full-time student at an accredited educational institution
- Minors under the age of 19 for whom the employee-member has court-ordered guardianship
- Foster children under the age of 19
- Children placed in the employee's home by court order pending adoption
- Natural, adopted and/or stepchildren who were disabled prior to age 19

Please note: If your dependent child is approaching age 19 and is disabled, application for such continuation of dependent status must be made within 31 days of the child's 19th birthday. You will need to provide verification that your dependent child has a qualifying permanent disability, in accordance with Social Security Administration guidelines, that occurred prior to his or her 19th birthday. Final eligibility will be determined by the Plan Administrator (refer to page 11) and documentation may be required periodically to continue a dependent on your plan.

Dependent Documentation Requirements

If you are enrolling a spouse or dependent whose last name is different from your own, the dependent's coverage will not be processed until supporting documentation, such as a marriage license for a spouse or a birth certificate or court order for dependents, is provided to your Human Resources Office.

Qualified Medical Child Support Order (QMCSO)
If a QMCSO exists, you must elect coverage for your dependent pursuant to the Order. You may not terminate coverage for a dependent covered by a QMCSO.

If You and Your Spouse are State Employees
If both you and your spouse are benefits-eligible State of Arizona or university employees, be sure to take into account the coverage that you each can elect.

- Each of you may elect single medical, dental and/or vision plan coverage, **OR**
- One of you may elect family medical, dental and/or vision plan coverage while the other elects no coverage or single coverage but under no circumstances may an employee elect dual coverage.

OTHER IMPORTANT INFORMATION

ID Cards
ID cards for your medical, dental and vision plans will arrive separately and are sent directly from the vendor to your home address. Typically, ID cards arrive seven to fourteen business days after your benefits become effective.

- MetLife Dental does not issue ID cards.
- Contact the vendor directly if you do not receive your cards or if you need additional or replacement cards.
- UnitedHealthcare, Delta Dental and Avesis allow members to print temporary ID cards from their website. This may be helpful if you need services before you receive your cards.
- BCBS (NAU only) PPO issues ID cards automatically upon enrollment. You may request additional ID cards from BlueCross BlueShield of Arizona's members website, BlueNet at www.bcbsaz.com.

Pretax Benefits
When your insurance premiums and contributions to your Flexible Spending Account(s) are made on a pretax basis, your taxable income is reduced. This means you will pay less state, federal and Social Security (FICA) taxes.

Federal regulations restrict the enrollment status changes that you can make during the plan year when your monthly insurance premiums are paid on a pretax basis to the following times:

- Annual Open Enrollment
- Qualified Life Events

The employee benefits that are eligible for pretax premium payments are:

- Medical insurance
- Dental insurance

- Vision insurance
- Employee life insurance up to $35,000
- Flexible Spending Accounts

After-Tax Benefits
Plans paid for with after-tax premiums do not have the same restrictions during the plan year. You can reduce or cancel after-tax plans without a Qualified Life Event. However, midyear enrollment can only occur in conjunction with an appropriate Qualified Life Event provided the request is made within 31 days of the event.

Examples of plans with after-tax premiums are:

- Short-Term Disability
- Life insurance over $35,000
- Dependent life insurance

Social Security
Any reduction in your taxable pay for Social Security purposes could lead to a reduction in your future Social Security benefits. Many employees find the reduction in future Social Security benefits insignificant when compared to the value of paying lower taxes today. However, if this is of concern to you, please consult a tax advisor for more information.

CHANGING YOUR BENEFITS

You may only change your benefit elections during the year if you experience a Qualified Life Event (QLE).

Qualifying Life Events include but are not limited to:

- Changes in your marital status: marriage, divorce, legal separation, annulment, death of spouse
- Changes in dependent status: birth, adoption, placement for adoption, death, or dependent eligibility due to age, marriage, or student status
- Changes in your employment status or work schedule that affect benefits eligibility
- Changes in your spouse's benefits coverage or eligibility
- Changes in a permanent residence that result in different available plan options for you, your spouse, and/or dependent(s)

Timeframe to Submit a Change Request
Requested benefit changes must be submitted to your Human Resources Office within 31 calendar days of the event. Failure to request a change within 31 days will result in the denial of benefit changes until the next QLE or annual Open Enrollment.

Effective Date of the Change
Consult with your Human Resources Office to determine whether or not the life event you are experiencing qualifies under the regulations, for the effective date of the change and for the documentation you are required to submit.

MEDICAL PLAN FEATURES

What is an "EPO" plan and how is this different from a "PPO" plan?
An EPO is an Exclusive Provider Organization; you must obtain services from a contracted network provider and your cost is a minimal co-pay. A PPO plan is a Preferred Provider Organization that allows in-network and out-of-network treatment. If you obtain out-of-network treatment, you will need to meet a plan year deductible and pay a percentage of all covered services.

The State offers "open access" in all of the EPO plans. What does this mean?
Open access refers to how you "access" physicians. You may schedule an appointment directly with any physician of your choosing without a referral. The provider MUST be contracted within your network.

If one of my doctors refers me to a specialist or medical provider that is NOT within my EPO network, am I responsible for the medical charges?
Yes. In the EPO plan, all medical services received must be with contracted network medical providers.

If your physician has scheduled an appointment for x-rays, laboratory tests, or specialists, you must make sure they are within your medical network.

If you are enrolled in the PPO plan, you may obtain out-of-network services and pay 30 percent of the covered charges, after you have met your deductible.

How do I find out what is covered in the health plan?
Covered benefits are detailed in a Plan Description. A plan description outlines your health insurance coverage and provides information on how claims will be paid, services that require pre-certification, services that are covered and items that are excluded by the health plan. You will receive a copy of the plan description after the beginning of a new plan year. You may also view these descriptions online at www.benefitoptions.az.gov.

What is a network service area?
A service area is the region in which a network's providers offer care.

- If you are a RAN+AMN, Schaller Anderson or Arizona Foundation member, you can get services state-wide; if you need services while traveling nationally, you would use the Beech Street PPO network to find a provider.
- Beech Street is the national PPO network for employees living permanently outside Arizona and for RAN+AMN, Schaller Anderson or Arizona Foundation members traveling outside Arizona.

- United Healthcare EPO members can receive services anywhere in the country by using a UHC EPO provider.
- United Healthcare PPO members can receive services anywhere in the country by using a UHC PPO in-network provider, a UHC PPO out-of-network provider or a UHC EPO provider.
- BlueCross BlueShield PPO coverage is available statewide and worldwide (NAU only).

What is a Plan Administrator?
A Plan Administrator is the contracted organization that processes the medical claims, provides customer service and runs the day-to-day operations of the health plan:

- If you are enrolled with Arizona Foundation, Beech Street, RAN+AMN, or Schaller Anderson, your Plan Administrator is Fiserv Health - Harrington.
- If you are enrolled with UnitedHealthcare, your Plan Administrator is UnitedHealthcare.
- If you are enrolled in the NAU only BCBS PPO, your Plan Administrator is BCBS.
- The ADOA Benefits Office is the Plan Sponsor not the Plan Administrator.

I've heard the terms, "integrated" and "non-integrated". What do they mean?
Integrated and non-integrated describe the way services are provided in each health plan:

- If you are enrolled with Arizona Foundation, Beech Street, RAN+AMN, or Schaller Anderson, you are in the non-integrated plan. This means multiple organizations supply the health plan services:
  - › Arizona Foundation, Beech Street, RAN+AMN and Schaller Anderson provide the networks of hospitals and medical providers.
  - › Fiserv Health - Harrington provides the claims payment processes, day-to-day operations, and customer service.
  - › Schaller Anderson provides the prior authorization, disease management, and medical review services.
- If you are enrolled with UnitedHealthcare, the integrated plan, UnitedHealthcare provides the following: hospital and provider networks, claims payment processes, day-to-day operations, prior authorization, and disease management services.
- Walgreens Health Initiatives (WHI) is a Pharmacy Benefit Manager and provides pharmacy services for both the integrated and non-integrated health plans.

What is a Pharmacy Benefit Manager?
A Pharmacy Benefit Manager provides the national network of pharmacies, mail-order service, and specialty pharmacy services. A Pharmacy Benefit Manager manages pharmacy benefits in the following ways: by providing bulk discounts on medications through the use of a formulary, by reviewing the way medications are used by members, and by implementing targeted programs to reduce overall pharmacy costs. These programs promote the use of cost-effective medications, maximize generic efficiency, and encourage proper utilization. A Pharmacy Benefit Manager also works with physicians to review medications prescribed and look for possible lower cost alternatives.

I have been contacted by someone and asked if I want to participate in a disease management program. What is disease management?
Disease Management is a voluntary service provided by Schaller Anderson or UnitedHealthcare to ASU and UA employees and by BlueCross BlueShield to NAU employees that assists members with treatment needs for chronic conditions. If you are being treated for any of the conditions listed below, you may be contacted by the Disease Management staff with further information on the program. This is a free service to provide you information, assistance, and resources to manage the following conditions:

- Asthma
- Congestive Heart Failure
- Diabetes
- Perinatal Care (before or after the birth of a baby)

What is Perinatal care? What services are available to me if I am pregnant or planning to become pregnant?
If you are pregnant, or planning to become pregnant, you can receive care and education through the Benefit Options Perinatal Program. This program helps future moms and their babies get a healthy start even before pregnancy begins. Resources available include:

- Preconception counseling
- Educational materials on common topics
- Screening and health assessment to help identify high risk pregnancies
- Special management of medical care by health professionals for expecting mothers with high risk pregnancies

Contact your Plan Administrator for more information on participation in these programs.

What is Coordination of Benefits?
When an employee is covered by more than one health plan, benefits are coordinated so that no more than 100 percent of the claim is paid to a medical provider. One plan will be considered primary and the other will be considered secondary. For additional information on how coordination of benefits will be applied, please refer to the appropriate Plan Description.

What is Transition of Care?
If you are a new employee and are changing providers, you may continue an active course of treatment with your current health care provider and receive in-network benefits during the pre-approved transition period. For additional information, please refer to the appropriate Plan Description.

Fiserv Health-Harrington is a proud partner of AZ Benefit Options. We work with a number of premier provider networks to provide compassionate, accurate and timely claim service, customer service, retiree premium billing, and COBRA premium billing to State of Arizona employees, retirees and their families.

You will receive all of the advantages of AZ Benefit Options–Harrington through our health care provider networks. Please refer to the ADOA service area map to find out which networks are in your area.

- Beech Street
- Arizona Foundation
- RAN+AMN
- Schaller Anderson Healthcare

Please visit www.myazhealth.com, a Website designed specifically for you by AZ Benefit Options–Harrington to find health care providers in your networks, review plan descriptions, find claim forms and information on a variety of health topics. You can check the status of your claims and eligibility as well.
For more information, call 888-999-1459.

Fiserv Health℠
Harrington

ONLINE FEATURES OF MEDICAL PLAN INFORMATION

Members can now review their personal profile, view the status of medical claims, obtain general medical information, and learn how to manage their own healthcare through the available health plan websites.

Arizona Foundation, Beech Street, RAN+AMN, or Schaller Anderson
Members enrolled with any of the networks above may view the following information on www.myazhealth.com (you will need to register with a user name and password):

• Personal Profile	Check your eligibility status and personal profile.
• Claims Inquiry	View and read the status of all medical claims submitted for payment, including billed charges, any deductibles or co-pays made, the amount paid to the provider, and details on provider payments.
• Deductible Status	View all of the co-pays and deductibles paid to date for tax purposes or the amounts accrued towards any plan maximums.
• Secure Mail	With the secure mail feature, you may ask questions any time day or night. You will receive replies about your confidential health benefit information within three business days without the worry of transmitting your personal information over the internet.
• Health Information	Compare hospitals based on quality of care, procedures, and patient safety measures. You may also view medical encyclopedia information on general health topics, and an outline of questions you should ask your doctor.
• Medline Plus	Medline provides extensive health information on over 650 diseases and conditions, a medical dictionary and encyclopedia information on clinical health trials, and the latest medical research in medicine.
• Provider Search	You may click on your network to research contracted network physicians, hospitals, and medical providers.
• Provider Information	You may view the status of your member eligibility and all claims submitted. You can even send and receive information through the secure mail feature.
• Claim Forms	You may download claim forms and information to submit claims for medical services and reimbursement for qualified out-of-pocket expenses.

UnitedHealthcare

Members enrolled in UnitedHealthcare can view the following information on www.myuhc.com (you will need to register with a user name and password):

• Personal Profile	Verify benefits and eligibility. Print a temporary or order a replacement ID card anytime.
• Provider Search	Find the physicians and hospitals that are convenient and right for you.
• Provider Information	You may view the status of your member eligibility and all claims submitted. You can even send and receive information through the secure mail feature.
• Claims Inquiry	View and read the status of all medical claims submitted for payment, including billed charges, any deductibles or co-pays made, the amount paid to the provider, and details on provider payments.
• Deductible Status	View all of the co-pays and deductibles paid to date for tax purposes or the amounts accrued towards any plan maximums.
• Hospital Comparison	Compare hospitals based on quality of care, procedures, and patient safety measures with the Hospital Comparison tool.
• Treatment Cost	Find out and compare what different treatments will cost using the Treatment Cost Estimator, before you need to make a decision.
• Health Information	Look up a variety of health conditions, procedures, and topics. You can research a condition for yourself or on behalf of a loved one with the website's evidence-based medical information from the prestigious Healthwise and BestTreatments organizations.
• Nurseline	Chat online with Registered Nurses seven days a week for trusted information and peace of mind when you have a question or during times when you cannot get to your doctor.
• Expert Information	Participate in monthly online events with leading experts in health care.

NAU Only BlueCross BlueShield of Arizona
Members enrolled in BlueCross BlueShield of Arizona can access the following information and services at BlueNet at www.bcbsaz.com (you will need to register with a login name and password).

- Personal Coverage Summary
- Claims Status
- Deductible Information
- Download Claims Forms
- Order ID Cards
- Medical and Pharmacy Benefits
- My BluePrint Health Assessment Tool
- Provider Directory

Members can access BlueNet, BlueCross BlueShield of Arizona's online member website at the following address: www.bcbsaz.com/.

MEDICAL PLANS COMPARISON CHART

	EPOs	PPOs	
These plans are available to employees statewide	RAN+AMN EPO Schaller Anderson EPO	Arizona Foundation PPO	
In addition to the plans above, the following plans are offered to employees in Maricopa, Gila, Pinal, Pima, and Santa Cruz counties	UnitedHealthcare EPO	UnitedHealthcare PPO	
This plan is available to employees living out of state.		Beech Street PPO	
DEDUCTIBLE/MAXIMUMS	In-Network Co-Pay	In-Network Co-Pay	Out-of-Network Out-of-Pocket
PCP REQUIRED FOR EACH MEMBER?	NO	NO	NO
PCP REFERRAL REQUIRED TO SEE A SPECIALIST?	NO	NO	NO
PLAN YEAR DEDUCTIBLES			
INDIVIDUAL	$0	$0	$300
FAMILY	$0	$0	$600
OUT-OF-POCKET MAXIMUMS			
INDIVIDUAL	$0	$1,000	$3,000
FAMILY	$0	$2,000	$6,000
LIFETIME MAXIMUMS	$0	$0	$2,000,000
PHYSICIAN SERVICES Office Visits/consultations, Specialist visits/consultations	$10 Max of 1 copay/day/provider	$10 Max of 1 copay/day/provider	30%* After Deductible
PREVENTATIVE CARE Well Baby, Child and Adult Physical Exams, Annual Well-Women Exams (GYN visit & PAP smear test) Annual Well-Man Exams (Office Visit & PSA blood test), Adult Immunizations (e.g., pneumonia, flu)	$10	$10	30%* After Deductible
MAMMOGRAPHY SCREENING (Coverage based on patient age or threat)	$0	$0	30%* After Deductible
OUTPATIENT SERVICES Freestanding ambulatory facility or hospital outpatient surgical center	$0	$0	30%* After Deductible
HOSPITALIZATION SERVICES Room & Board (private room when medically necessary)	$0	$0	30%* After Deductible
Intensive Care	$0	$0	30%* After Deductible
Surgeons and Assistants, Anesthesiologists, Pathologists, Radiologist	$0	$0	30%* After Deductible
EMERGENCY CARE Urgent Center Care	$20	$20	30%* After Deductible
Emergency room	$75, waived if admitted	$75, waived if admitted	$75, waived if admitted
Ambulance (for medical emergency or required interfacility transport	$0	$0	Emergency paid at in-network benefit rate
CHIROPRACTIC	$10	$10	30%* After Deductible
PRE-EXISTING CONDITIONS	NO	NO	NO
DURABLE MEDICAL EQUIPMENT	$0	$0	30%* After Deductible
BEHAVIORAL HEALTH			
Outpatient	$10	$10	30%* After Deductible
Inpatient	$0	$0	30%* After Deductible

** Percentages paid based on Reasonable and Customary Charges*
For the NAU only BCBS PPO plan details, go to http://hr.nau.edu/m/ and choose Benefits, Health, BCBS Plan Book.

NETWORK PLAN COVERAGE FOR ROUTINE AND URGENT/EMERGENCY CARE

	EPOs		PPOs	
	UnitedHealthcare	RAN+AMN Schaller Anderson	Arizona Foundation UnitedHealthcare	Beech Street
ROUTINE MEDICAL CARE				
Routine medical care means a regular course of treatment that is anticipated, expected, and planned for. Routine medical care is usually conducted in the medical provider's office.				
Central and Southern Arizona	Covered	Covered	Covered	Covered
Rural Arizona	Covered	Covered	Covered	Covered
Traveling in United States	Covered with UnitedHealthcare Provider	Covered with Beech Street Provider	Covered	Covered
Living Outside of Arizona	Covered with UnitedHealthcare Provider	Covered with Beech Street Provider	Covered	Covered
International Travel	Not Covered	Not Covered	Covered	Covered
URGENT AND EMERGENCY CARE				
Emergency care means the medical, psychiatric, surgical, hospital, and related health care services required to stabilize an injury or serious illness that could result in serious medical complications, loss of life, or permanent physical impairment				
Central and Southern Arizona	Covered	Covered	Covered	Covered
Rural Arizona	Covered	Covered	Covered	Covered
Traveling in United States	Covered	Covered	Covered	Covered
Living Outside of Arizona	Covered	Covered	Covered	Covered
International Travel	Covered	Covered	Covered	Covered

Covered benefits subject to plan provisions.

Choose the Health Plan chosen by more State of Arizona Employees

UNITEDHEALTHCARE®

UnitedHealthcare takes an active role in providing the tools and information to keep our members healthy, active and involved in their health, 24 hours a day, 7 days a week.

Join over 30,000 State of Arizona employees and 1.2 million members statewide and receive the following benefits:

- 24-hour access to the health information and support you need from a staff of caring, registered nurses. Simply call NurseLine℠ toll-free for information and education on any health concern, at no cost to you.
- Access to personal information anytime, anywhere on **myuhc.com**.® Check claim status, request a replacement ID card, find a physician or hospital and access health information and educational resources.
- Access to UnitedHealthcare's network of 7,645 physicians and 69 hospitals in Arizona, and a nationwide network of over 500,000 physicians and 4,600 hospitals.
- Care from any physician or hospital in our extensive network, without having to get a referral.

Choose UnitedHealthcare's EPO plan today!

UnitedHealthcare®
It just makes sense.®

If you have questions about our health care benefits, call us at **1-800-896-1067.**

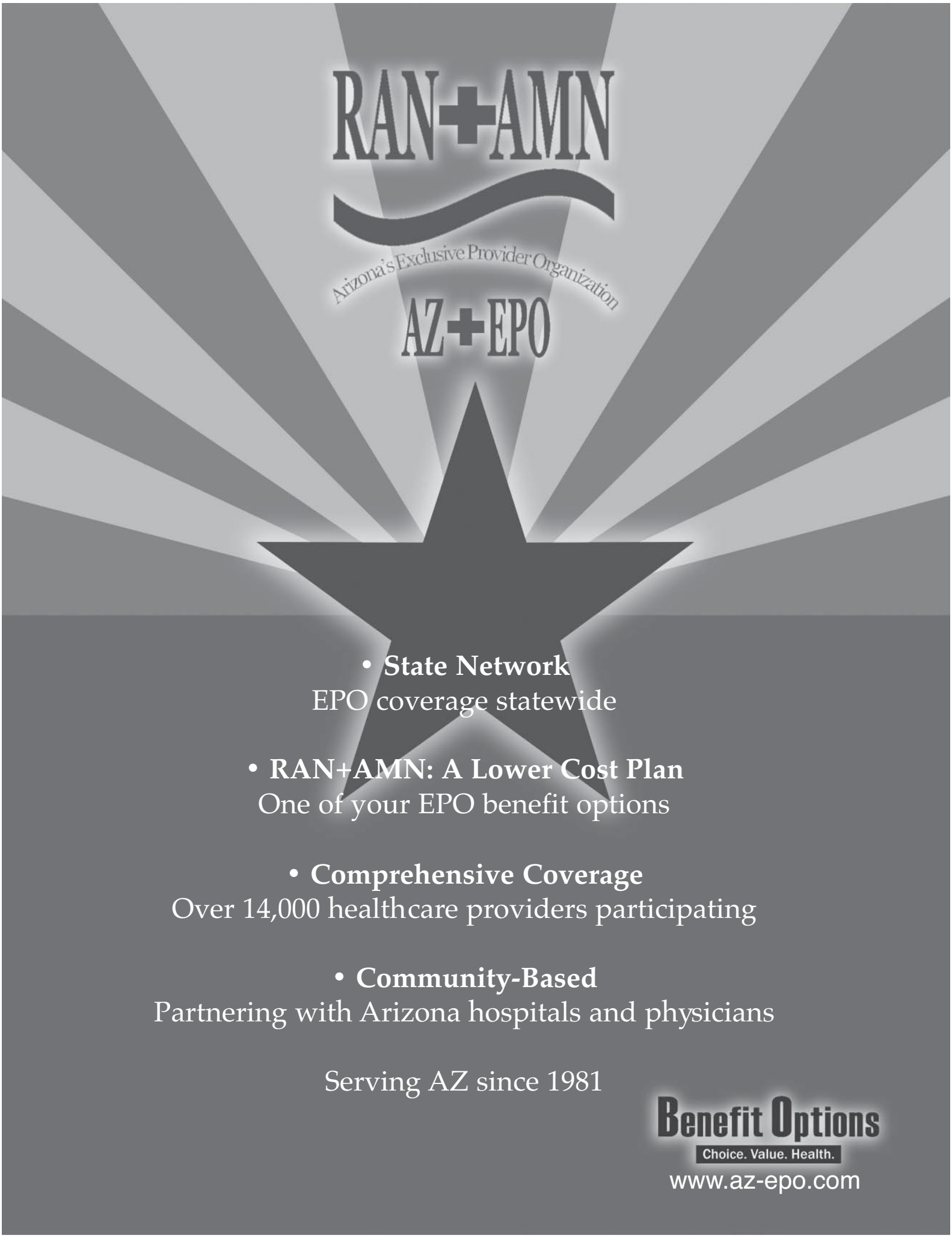
SCHALLER ANDERSON
HEALTHCARE

State of Arizona employees, now's the time to join the 60,000 employees and family members who already put their trust in Schaller Anderson. You'll have access to more than 9,000 Arizona health care providers, including Mayo Clinic. You'll also participate in one of the least expensive options available. During open enrollment, choose a company that has been earning Arizona's trust since 1986. Choose Schaller Anderson.

www.schallerandersonhealth.com

Celebrating Excellence 1986 SCHALLER ANDERSON 2006 In Health Care

Benefit Options
Choice. Value. Health.


RAN+AMN
Arizona's Exclusive Provider Organization
AZ+EPO
• State Network
EPO coverage statewide
• RAN+AMN: A Lower Cost Plan
One of your EPO benefit options
• Comprehensive Coverage
Over 14,000 healthcare providers participating
• Community-Based
Partnering with Arizona hospitals and physicians
Serving AZ since 1981
Benefit Options
Choice. Value. Health.
www.az-epo.com

PHARMACY PLAN FEATURES

If you elect any Benefit Options medical plan, Walgreens Health Initiatives (WHI) will be the network you use for pharmacy benefits. Enrollment is automatic when you enroll in a medical plan, and there is no separate cost.

The WHI network consists of more than 54,000 participating chain and independent pharmacies nationwide, with 900 member pharmacies in Arizona. All prescriptions must be filled at a network pharmacy or through the mail order service. The cost of prescriptions filled out-of-network will not be reimbursed. To find a pharmacy near your home, work address, out-of-town vacation address, or your dependent student's out-of-state address, refer to www.mywhi.com.

Multilingual customer service representatives are available 24 hours a day, 7 days a week at 1.866.722.2141 to assist you.

The WHI plan has a three-tier formulary; the cost for up to a 30-day supply of medication bought at a retail pharmacy is $10 for a generic drug, $20 for a preferred (formulary) drug, and $40 for a non-preferred (non-formulary) drug. You can find information on WHI's formulary and look up the cost for specific drugs at www.mywhi.com.

The Walgreens Health Initiatives Preferred Medication List (PML), also known as a formulary, is a list of medications that will allow you to maximize the value of your prescription benefit. These medications, chosen by a committee of doctors and pharmacists, are lower-cost generics and brand names that are available at a lower cost than their more expensive brand-name counterparts. The PML is updated quarterly, and as needed throughout the year to add significant new medications as they become available. Medications that no longer offer the best therapeutic value for the plan are deleted from the PML once a year, and a letter is sent to any member affected by the change. To see what medications are on the PML, log on to mywhi.com or contact the WHI Customer Care Center to have a copy sent to you. Sharing this information with your doctor helps ensure that you are getting the medications you need, and saving money for both you and your plan.

A convenient and less expensive mail order service is available for employees who require maintenance medications for on-going health conditions, or who are going to be in an area with no participating retail pharmacy for an extended period of time. Here are some of the guidelines and benefits of using the mail order service:

- You must submit a written 90-day prescription from your physician for any new mail order drug.
- You may request up to a 90-day supply of medication for two co-pays.
- You may pay by check or charge your co-pay to a Visa, MasterCard, American Express, or Discover account.
- You may register your email address to receive information on your orders.
- You can order refills online at www.mywhi.com or via phone at 1.866.722.2125.
- One-on-one consultations with a licensed pharmacist are also available at this number.

HEALTH MANAGEMENT PROGRAMS

Clinical Prior Authorization

Prescriptions for certain medications or circumstances require approval from your physician before they can be filled, even with a valid prescription. Prescriptions may be limited to quantity, frequency, dosage, or may have age restrictions. The authorization process may be initiated by you, your local pharmacy, or your physician by calling WHI at 1.877.665.6609, Monday through Friday, 8:00 a.m. to 8:00 p.m.

Specialty Pharmacy Program

Certain medications used for treating chronic or complex health conditions are handled through the WHI Specialty Pharmacy. This program assists you with monitoring your medication needs for certain conditions and by providing patient education. The Specialty Pharmacy Program includes monitoring of specific injectable drugs and other therapies requiring complex administration methods, special storage, handling, and delivery. Specialty medications are limited to a 30-day supply and may be obtained only at a Walgreens retail pharmacy or via the mail order service. Call WHI at 1.888.782.8443 for further information on this program.

A Specialty Care Representative may contact you to facilitate your enrollment in the WHI Specialty Pharmacy Program. Trained Specialty Care pharmacy staff are available 24 hours a day, 7 days a week, to assist you. You may also enroll directly into the program by calling 1.888.782.8443.

Non-Covered Drugs

Certain medications are not covered as part of the Benefit Options plan. If you find such a drug has been prescribed for you, discuss an alternative treatment with you doctor.

NAU Only BlueCross BlueShield Pharmacy Plan

There is no need to elect or enroll in this plan; it is part of your Medical Plan coverage. Prescription drug benefits are available at four cost-sharing levels. The amount you pay depends on the specific drug dispensed by the pharmacy. The pharmacy will charge you a generic, preferred brand, non-preferred brand A or non-preferred brand B co-payment. The BCBSAZ Prescription Medication Guide can be used to determine your co-payment and can be found on the BCBS website at www.bcbsaz.com/pharmacy. Go to 4 level prescription drug benefit.

Up to a 90-day supply of maintenance drugs may be obtained through the Prescription Drug Mail Order Program. Maintenance drugs are drugs taken consistently. The co-payment for a 90-day mail order supply is the same as the co-payment for a 30-day supply through a pharmacy.

More complete information on your prescription drug benefit can be found in the BCBS benefit plan booklet at www.hr.nau.edu/m/. Go to Benefits, Health, BCBS Plan Book.

ONLINE FEATURES OF PHARMACY PLAN INFORMATION

Walgreens Health Initiatives (WHI)

All members enrolled in Arizona Foundation, RAN+AMN, Schaller Anderson and UnitedHealthcare can view pharmacy information by registering at www.mywhi.com:

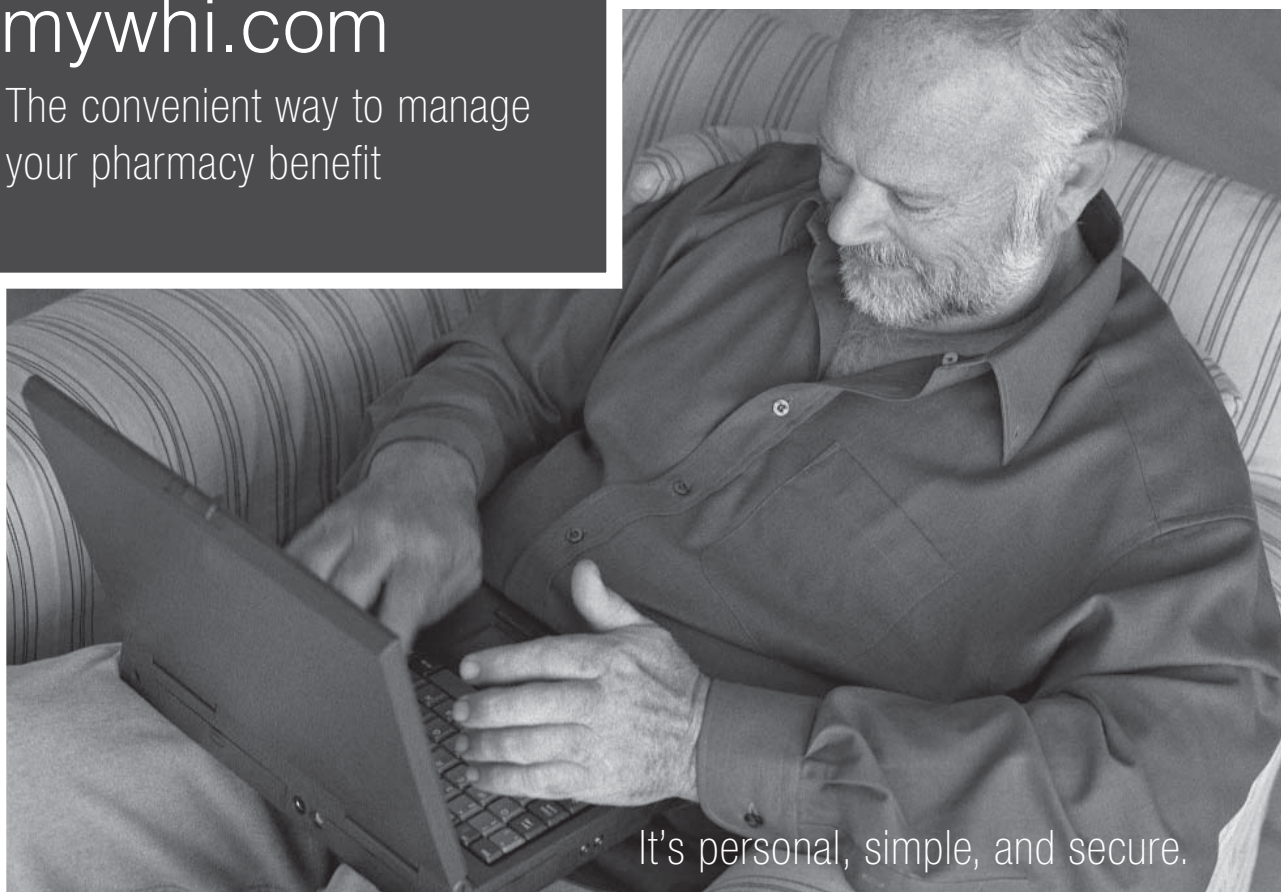
• Co-pay and Drug Information	You may research your medication to learn what co-pay is required at retail or through mail-order service.
• Eligibility Information	Check the eligibility status for you and your family members.
• Search the Formulary	You may research medications to determine whether they are generic, preferred, or non-preferred drugs. This classification will determine which co-pay is required.
• Download the Formulary	You may print a copy of the formulary to work with your medical provider on locating the right cost-effective medication for you.
• Locate a Nearby Pharmacy	You may view pharmacies in your area by zip code or city.
• Mail Service Forms	You may register for mail order service by downloading the registration form and following the step-by-step instructions.
• Prescription History	You may view your entire prescription history, including all of the medications received by each member.
• Refill Information	You may review refill information, including when your next refill can be ordered and available options to request your next refill.
• Drug Information	You may research information on prescribed drugs to include the uses of the drug, how to use the drug, side effects, precautions, drug interactions, and what to do if there is an overdose.
• Product News	The latest product news is available including drug recalls and industry advances in the pharmaceutical industry.

NAU only: *BCBS members can access BlueNet, BlueCross BlueShield of Arizona's online member website at the following address: www.bcbsaz.com/. Information on the pharmacy plan and co-payment levels for prescriptions can be found at www.bcbsaz.com/pharmacy; go to 4-level prescription drug benefit.*

Looking to save time and money on your prescriptions?

mywhi.com

The convenient way to manage your pharmacy benefit



Register today and take advantage of our many timesaving features:

- Look up your drug **coverage** and **copayments**.
- Find generic and **lower-cost** alternatives.
- See up to 18 months of your **prescription history**.
- **Locate** a network pharmacy.
- Learn more about your **medications**.
- Register for mail service to:
  - **Order refills** online
  - Check **prescription status**

You may register on or after the date your prescription coverage begins. Access to certain features may depend upon your benefit design.

Walgreens Health Initiatives

PBM4574-0706

DENTAL PLAN FEATURES

Prepaid Plans

- You must see a Participating Dental Provider (PDP) to provide and coordinate all of your dental care.
- No annual deductible or maximums, except a $200.00 maximum reimbursement for non-contracted emergency services.
- No claim forms (except for emergency services under EDS).

Assurant Benefits
Each family member must select his or her own dentist from a group of participating dentists. Each family member may select and change his or her dentist by calling Assurant Benefits Customer Service. Members may self-refer for in-network specialty care.

Employers Dental Services (EDS)
Employers Dental Services is the largest prepaid dental plan with the largest general dentist network in the State of Arizona. EDS is headquartered in Tucson, Arizona with offices in both Tucson and Phoenix.

Indemnity/PPO Plans

- You may see ANY licensed dentist anywhere in the world.
- Deductible and/or out-of-pocket payments apply.
- You have a maximum benefit of $2,000 per person per plan year for dental services.
- There is a maximum lifetime benefit of $1,500 per person for orthodontia.
- You may need to submit a claim form for eligible expenses to be paid.
- Benefits may be based on reasonable and customary charges.

Delta Dental
Over 80 percent of Arizona's licensed dentists participate in the Delta Dental Plan and agree to accept Delta's allowable fee as payment in full after any deductibles and/or co-payments are met. Amounts billed by network providers in excess of the allowable fee will not be billed to the patient. If you choose to see a non-participating dentist, Delta will still provide benefits, although typically at reduced levels.

MetLife Dental
MetLife participating dental providers accept negotiated fees as payment in full after your deductibles and co-payments are met. These fees are typically 15 to 30 percent below average rates. Non-covered services provided by a participating dentist are also charged at a lower rate. Covered expenses from a non-participating dentist are paid according to established reasonable and customary charges.

For a complete listing of covered services for each plan, please refer to the Plan Descriptions. Occasionally, covered services and supplies are subject to change based on the American Dental Association Guidelines. These changes may also result in a change to your co-payment.

DENTAL PLANS

	In Arizona	Outside Arizona, In U.S.	International
PREPAID PLANS			
Assurant			
Routine Care	X		
Emergency Services	X	X	X
Employers Dental Service			
Routine Care	X		
Emergency Services	X	X	X
PPO PLANS			
Delta Dental			
Participating Dentist Services	X	X	
Non-Participating Dentist Services	X	X	X
MetLife			
Participating Dentist Services	X	X	
Non-Participating Dentist Services	X	X	X

DENTAL PLANS COMPARISON CHART

	Employers Dental Services/EDS	Assurant*	Delta Dental	MetLife Dental
PLAN TYPE	Prepaid	Prepaid	Indemnity/PPO	Indemnity/PPO
DEDUCTIBLES	None	None	$50/$150	$50/$150
PREVENTIVE CARE	(Co-Payments)	(Co-Payments)	(Co-payments)	(Co-Payments)
Office Visit	$5	$5	$0 Deductible Waived	$0 Deductible Waived
Oral Exam	$0	$0	$0 Deductible Waived	$0 Deductible Waived
Prophylaxis/Cleaning	$5	$3	$0 Deductible Waived	$0 Deductible Waived
Fluoride Treatment	$0	$0	$0 Deductible Waived	$0 Deductible Waived
X-Rays	$0	$0	$0 Deductible Waived	$0 Deductible Waived
BASIC RESTORATIVE				
Office Visit	$5	$5	20%	20%
Sealant (to age 19)	$12/tooth	$5/tooth	20%	20%
Filings	$12-$25 (amalgam)	$10-$20 (amalgam)	20%	20%
Extractions	$15 (single)	$15 (single)	20%	20%
Periodontal	$200 Per Quadrant	$200 Per Quadrant	20%	20%
Oral Surgery	$15-$110	$15-$110	20%	20%
MAJOR RESTORATIVE				
Office Visit	$5	$5	50%	50%
Crowns	$225-$275 +Lab	$235 + Lab	50%	50%
Dentures	$300 + Lab	$325 + Lab	50%	50%
Fixed Bridgework	$225-$235 + Lab	$235 + Lab	50%	50%
Crown/Bridge Repair	$5 + Lab	$20-$45 + Lab	50%	50%
Inlays	$112-$125	$130-$240 + Lab	50%	50%
ORTHODONTIA				
Child	25% discount of Plan Specialist normal retail	25% discount of Plan Specialist normal retail	50%	50%
Adult	25% discount of Plan Specialist normal retail	25% discount of Plan Specialist normal retail	50%	50%
TMJ SERVICES				
Exam, services, etc.	Up to 25% of normal fees	Up to 25% of normal fees	No coverage	No coverage
MAXIMUM BENEFITS				
Annual combined preventive, basic, and major services	No dollar limit	No dollar limit	$2,000/person	$2,000/person
Orthodontia Lifetime	No dollar limit	No dollar limit	$1,500/person	$1,500/person

**Serives must be provided by a contracted dentist. Co-pays listed apply when a Participating Dental Provider is used. You may receive services from a contracted specialist, without a referral, for a higher co-pay or discounted fee. See Plan brochures for specifics.*

WE GIVE ARIZONA'S STATE EMPLOYEES A REASON TO SMILE FROM

EAR TO EAR.

Whether it's Delta Dental's roster of dentists – literally thousands – located all over the state, or our friendly, local service with less paperwork, more people choose Delta Dental than any other dental plan. It's no wonder that Arizona's No. 1* dental plan is also the dental plan chosen by more State Employees. Find out what so many of your co-workers and their families are smiling about! **Visit www.deltadentalaz.com.**

DELTA DENTAL®

*Rated No.1 according to *The Business Journal Book of Lists*, 2006 and *Ranking Arizona*, 2006.

Are your Dental Benefits Appropriate?

MetLife®

Now you can plan for unexpected dental care costs with the MetLife® Preferred Dentist Program (PDP)!

Here's what you get with the PDP:

- **Freedom of choice:** Freedom to visit any dentist whether or not he or she participates in the PDP. Plus, you don't need to select a primary dentist or obtain referrals to see a specialist.
- **Broad network access:** Access to a seamless national network of over 88,000 participating PDP dentist locations including over 20,000 specialty locations.
- **Valuable cost savings:** Typically, save 10% to 35% below the average fees of dentists in your area when you visit a participating PDP dentist. These dentists agree to accept scheduled fees as payment-in-full for services rendered.
- **Valuable benefit coverage:** Competitive coverage for preventive services as well as more complex dental procedures.
- **Superior claim service:** Making sure you have a great experience with us is our commitment to you. MetLife processes 85% of dental claims in five business days or less. And, if you have questions about your plan benefits, simply call 1-800-942-0854 or log on to www.metlife.com/mybenefits to access tools and information you may want to review to be a better-informed user of your dental plan.

Join us and see what everyone is smiling about!

L060738LL(exp0707)MLIC-LD 0607-1597

Metropolitan Life Insurance Company, 200 Park Avenue, New York, NY 10166 www.metlife.com

VISION PLAN FEATURES

Coverage for vision examinations and corrective eyewear is available to all benefits-eligible employees and their qualified dependents through Avesis, Inc. Employees are responsible for the full premium cost of this voluntary plan.

You may receive services from either a participating or a non-participating provider once a plan year; exceptions are the Lasik benefit which is available one time only and the additional eyewear benefit which you may use as many times as you wish.

To find a participating provider, either go online at www.avesis.com or call 800.828.9341, call the provider and identify yourself as an Avesis member and schedule your appointment.

If services are received from a non-participating provider, you will pay the provider at the time of service and submit a claim to Avesis for reimbursement. The claim must be filed within three months from the date of service and include your name, member ID number and mailing address, the patient's name and date of birth, the group name and number, and an itemized statement of services.

Participating Provider Fee Schedule

Participating Provider	Copay	Benefit/Allowance After Copay
1) Vision examination and one of the following:	$10	
a) Single, bifocal, trifocal, or lenticular lenses and frames		$100-$150 retail value
Progressive lenses and frames		20% off retail minus $50 allowance for lenses and $100-$150 retail value of frame
b) Contact Lens: Elective		$130 toward fitting fee and/or contacts
Contact Lens: Medically Necessary*		Covered 100%
c) Lasik Surgery		$150 toward one or both eyes
2) Additional Options		20% discount from provider's fee (i.e., tints, coatings)
3) Additional eyewear		Avesis contracted discounted fee

** Contact lenses would be considered medically necessary for the following conditions: a) post cataract surgery; b) keratoconus; c) certain conditions of anisometropia; d) extreme visual conditions that cannot be corrected with spectacle lenses. Determination of medical necessity is made by Avesis.*

Nonparticipating Provider Fee Schedule

Non-Participating Provider	Allowance Up To:
Vision Examination	$50
Single Vision Lenses	$30
Bifocal Lenses	$45
Trifocal Lens	$55
Lenticular Lenses	$110
Progressive Lenses	$45
Frames	$50
Contact Lens	
Elective	$150
Medically Necessary	$300
Lasik Surgery	Not Covered

Over 30,000 Arizona State Employees trust Avesis as their vision care provider.

*With the Avesis Vision Plan, employees can save up to $150 per year on exam, frames, spectacle lenses or contacts. Families can save over $500! **

Are you one of them?

Avesis continues to be the State of Arizona's vision care provider for a sixth straight year.

Join your colleagues.

Sign up for the Avesis voluntary vision plan during this open enrollment season.

VISION BENEFITS

Avēsis
A National Vision and Dental Company

3724 North 3rd Street
Suite 300
Phoenix, AZ 85072

FOR MORE INFORMATION ABOUT YOUR STATE OF ARIZONA VISION BENEFITS PLEASE CONTACT CUSTOMER SERVICE AT 1-800-828-9341 OR VISIT WWW.AVESIS.COM/ARIZONA

*Actual savings may be more or less depending on frame selection, lens options and special purchases.

ARIZONA, NATIONAL AND INTERNATIONAL COVERAGE (MEDICAL, DENTAL, AND VISION)

	Within Arizona	Within U.S.	International
MEDICAL			
EPO Plans			
RAN+AMN	Covered in-network	Covered using Beech Street Provider	Emergency and Urgent Only
Schaller Anderson	Covered in-network	Covered using Beech Street Provider	Emergency and Urgent Only
UnitedHealthcare	Covered in-network	Covered using UHC PPO in/out-network or UHC EPO provider	Emergency and Urgent Only
PPO Plans			
Arizona Foundation	Covered in/out-network	Covered using AZF PPO in/out-network or Beech Street Provider	Covered out-of-network
Beech Street	Covered in/out-network	Covered in/out-network	Covered out-of-network
UnitedHealthcare	Covered in/out-network	Covered using UHC PPO in/out-network or UHC EPO provider	Covered out-of-network
NAU Only			
BlueCrossBlueShield PPO including BCBS Prescription Plan	Covered in/out-network	Outside AZ: Covered as in-network only if you receive covered services from a provider who participates as a PPO provider with the local BCBS plan. For assistance in locating a local BCBS network provider in another state, call 1.800.810.2583.	For assistance with locating a provider and submitting claims, call 1.800.810.2583 or 1.804.673.1686. For an international claim form, go to www.bcbs.com/bluecardworldwide/index.html
PHARMACY			
Walgreens Health Initiatives	Covered in-network	Covered in-network	Not Covered
DENTAL			
Prepaid Plans			
Assurant	Covered in-network	Emergency Only	Emergency Only
EDS	Covered in-network	Emergency Only	Emergency Only
PPO Plans			
Delta Dental	Covered in/out-network	Covered in/out-network	Covered out-of-network
MetLife Dental	Covered in/out-network	Covered in/out-network	Covered out-of-network
VISION			
Avesis	Covered in-network	Covered out-of-network	Covered out-of-network

Note: Treatment will be subject to the Plan Description

NATIONAL AND INTERNATIONAL TRAVEL ASSISTANCE

As a participant in the Standard Basic Life Insurance plan, you and your eligible dependents are automatically covered by this assistance service when you travel 100 or more miles from home, whether for business or pleasure, for trips up to 90 days.

Pre-Trip Assistance

- Consulate and embassy locations
- Currency exchange information
- Health hazards advice and inoculation requirements
- Passport and visa information
- Weather information
- Hotel and airport locator service

Medical Assistance

- Locating medical care
- Assist in communications with medical providers
- Provide translation and interpreter services 24/7 if you are outside of the United States
- Hotel convalescence arrangements
- Medical insurance coordination for medical care
- Prescription drug assistance to obtain emergency or needed medications

Emergency Transportation Services

Services are covered up to a combined single limit of $150,000. Related medical services, medical supplies, and a medical escort are covered where applicable and necessary:

- Repatriation if it is medically necessary after initial treatment and stabilization.
- Family or friend travel arrangements if you are hospitalized for more than 7 days and are traveling alone. MEDEX will provide round-trip economy airfare for one family member or friend to the location of your hospital.
- Return of dependent children if you are hospitalized for more than 7 days - to coordinate the return of a dependent back to the United States. MEDEX will provide one-way economy airfare for children under age 18 to their permanent residence, including an escort for children, if necessary.
- Vehicle return if you require emergency evacuation or repatriation.

Travel Assistance Services

- Emergency credit card and ticket replacement for lost, stolen, or damaged cards or tickets
- Emergency passport and document replacement for lost, stolen, or damaged passports or travel documentation

- Emergency cash and payment assistance
- Emergency message service to relay information to family members
- Missing luggage assistance
- Location of legal assistance
- Bail bond services

Personal Security Services
MEDEX provides real-time security intelligence in the event you feel you are threatened due to political unrest, social instability, weather conditions, health or environmental hazards.

How to Access Services
Contact MEDEX at 1.800.633.8575. To read more about the program and print a travel assist ID card, go to www.standard.com/eforms/12092w.pdf. The Group Number for the State of Arizona is 7088.

STANDARD LIFE INSURANCE BENEFITS

Basic Life Insurance and AD&D
You are automatically covered for $15,000 of basic life insurance at no cost to you. An additional $15,000 for Accidental Death and Dismemberment (AD&D) insurance and a $15,000 Seat Belt Benefit may also be payable if you die in an automobile accident and are wearing a seat belt. You are automatically covered in these three programs.

Supplemental Life Insurance and AD&D
Supplemental life insurance coverage is available to employees who would like additional life insurance beyond what the State provides. Your cost is based on your age as of October 1 each plan year. Your employee supplemental AD&D coverage is the same as the supplemental life amount that you elect. The maximum amount of supplemental life insurance that you can elect through the State's group plan is three times your annual base salary, or $300,000, whichever is less.

When electing or changing supplemental life after the initial offering, you may increase or decrease your supplemental life coverage, in multiples of $5,000, up to a maximum $20,000 increase per year. You may cancel your pretax supplemental life coverage under certain limited circumstances. Supplemental life coverage above $35,000 is paid on an after-tax basis, and may be cancelled at any time.

In the event of your death, employee life and AD&D benefits are paid to your designated beneficiary. It is important to keep your beneficiary information current. You may change your beneficiary using the web enrollment system during Open Enrollment. Remember: adding a beneficiary does not automatically delete a previously-designated beneficiary. If you wish to change a previously-designated beneficiary, you must actively do so while enrolling via the website. If you wish to change your beneficiary outside of the Open Enrollment

period, contact your Human Resources office.

NAU employees may view and edit their beneficiaries at anytime throughout the year by logging onto the Peoplesoft Louie System. From the Faculty and Staff Services page, under the heading Benefits Info, click on View your life insurance and change beneficiaries.

Dependent Life Insurance
You may purchase Spouse and Dependent Life Insurance coverage as a separate election from your Supplemental Life Insurance coverage. Please refer to the eligible dependent section on page 8 of this Guide for a definition of eligible spouse and eligible dependent. Your spouse and eligible children are each insured for the amount you elect: $2,000; $4,000; $6,000; $12,000; or $15,000.

If you elect coverage for your dependents, you are automatically the beneficiary for your spouse and children.

AETNA SUPPLEMENTAL LIFE INSURANCE*

Arizona State University and Arizona Board of Regents
You pay all premiums for the Aetna life insurance coverage amount that you elect. You may apply for coverage in increments of one, two, or three times your annual salary rounded up to the nearest $1,000. The maximum you may apply for is three times your annual salary or $100,000, whichever is less. Dependent life insurance coverage for your spouse in the amount of $5,000 and for your children in the amount of $2,500 is automatically included. During your initial new hire/eligibility enrollment, you may elect up to the maximum coverage available to you. Thereafter, changes in coverage are restricted to one level increase during Open Enrollment and are subject to proof of insurability and approval by Aetna. Coverage levels automatically adjust for changes to your age and salary.

The University of Arizona
You pay all premiums for the Aetna life insurance coverage amount that you elect. You may apply for coverage in increments of one, two, or three times your annualized salary rounded up to the nearest $1,000. The maximum you may apply for is three times your annualized salary or $300,000, whichever is less. Dependent life insurance coverage for your spouse in the amount of $5,000 and for your children in the amount of $5,000 is also available when supplemental coverage is elected. An Accidental Death and Personal Loss double indemnity benefit is provided with employee supplemental life coverage. During your initial new hire/ eligibility enrollment or a Qualified Life Event change, you may elect up to the maximum coverage available to you. Thereafter, changes in coverage are restricted to one option level increase at Open Enrollment. Coverage levels automatically adjust for changes in your age and salary.

Refer to the Summary of Coverage for additional information.

Northern Arizona University

You pay all premiums for the Aetna life insurance coverage amount that you elect. You may apply for coverage in increments of one, two or three times your annual salary rounded to the nearest $1,000. The maximum you may elect is three times your annual salary or $150,000, whichever is less. Dependent life insurance coverage is also available when supplemental coverage is elected. Option 1 provides $10,000 spouse/$5,000 child(ren) and Option 2 provides $5,000 spouse / $2,500 child(ren). During your initial new hire/eligibility enrollment, you may elect up to the maximum coverage available to you. Thereafter, changes in coverage are restricted to one option level increase at Open Enrollment or a Qualified Life Event change. Coverage levels automatically adjust for changes to your age and salary.

SUPPLEMENTAL LIFE INSURANCE COMPARISON

AGE	STANDARD (per $1,000 coverage)	AETNA ABOR & ASU (per $1,000 coverage)*	AETNA NAU (per $1,000 coverage)*	AETNA UA (per $1,000 coverage)*
18-24	$0.10	$0.13	$0.04	$0.06
25-29	$0.10	$0.15	$0.06	$0.06
30-34	$0.12	$0.16	$0.07	$0.06
35-39	$0.14	$0.20	$0.09	$0.10
40-44	$0.24	$0.23	$0.14	$0.16
45-49	$0.32	$0.29	$0.21	$0.26
50-54	$0.52	$0.37	$0.31	$0.32
55-59	$0.74	$0.48	$0.42	$0.50
60-64	$1.34	$0.63	$0.58	$0.76
65-69	$1.34	$0.92	$0.80	$1.14
Age 70+	$2.12	Contact your benefit office for premium rate		
Election Options	Elect in $5,000 increments. Increases may not exceed $20,000 per plan year after initial new hire enrollment.	Option A 1x annual salary; Option B 2x annual salary; Option C 3x annual salary. Increases may not exceed one step per plan year after initial new hire enrollment.	Option A 1x annual salary; Option B 2x annual salary; Option C 3x annual salary. Increases may not exceed one step per plan year after initial new hire enrollment.	Option 1 1x annual salary; Option 2 2x annual salary; Option 3 3x annual salary. Increases may not exceed one step per plan year after initial new hire enrollment, or unless you experience a Qualified Life Event.
Minimum Coverage	$5,000	1x annual salary rounded up to nearest $1,000	1x annual salary rounded to nearest $1,000	1x annual salary rounded up to nearest $1,000
Maximum Coverage	$300,000 or 3x annual salary, whichever is less	$100,000 or 3x annual salary, whichever is less	$100,000 or 3x annual salary, whichever is less	$300,000 or 3x annual salary, whichever is less
Spouse & Dependent Coverage	Mo. Cost $ 2,000 $0.94 $ 4,000 $1.88 $ 6,000 $2.82 $12,000 $5.64 $15,000 $7.06	Included: $5,000 spouse $2,500 each child	Option 1 $10,000 spouse $5,000 each child; Option 2 $5,000 spouse $2,500 each child.	$5,000 spouse $5,000 each child Monthly Cost $0.66
Portability/Conversion Options	•Conversion Option	Refer to Summary of Coverage	Refer to Summary of Coverage	•Portability and Conversion Option •Retiree Continuation Option
Other Features	• Accidental Death & Personal Loss Double Indemnity •Seatbelt Incentive •Non Smoker	• Accidental Death & Personal Loss Double Indemnity	• Accidental Death & Personal Loss Double Indemnity •Waiver of Premium •Benefit for Total Disability	• Accidental Death & Personal Loss Double Indemnity

**Coverage levels automatically adjust for changes in salary*

SHORT-TERM DISABILITY (STD) INSURANCE

You can elect short-term disability coverage through Standard Insurance Company or UnumProvident. When electing coverage, you may select only one provider.

Standard Insurance Company

If you elect Standard STD and become unable to work due to pregnancy or a non-work related injury or illness, you may receive a weekly benefit up to 66 ⅔% of your weekly base pay for a period up to six months. There are no pre-existing condition limitations, but you must meet the actively-at work provision at the time of enrollment; coverage will not become effective until the provision is met.

If coverage is elected during your initial new hire/eligibility enrollment period, your benefits will start on your first day of disability due to accident or the 31st day of disability due to illness or pregnancy.

If you previously waived STD coverage and enroll during Open Enrollment or Qualified Life Event change period and become disabled during the first 12 months of coverage, your benefits will start on the 61st day of disability due to illness or pregnancy.

The Standard STD plan provides a Return-to-Work incentive program. Contact your Human Resources Office for additional information on the Return-to-Work provision.

Your monthly cost is $0.87 per $100 of your monthly base salary, up to a maximum of $5,000 of monthly salary for computation and benefit purposes, deducted on an after-tax basis from your paycheck.

UnumProvident

The UnumProvident STD plan pays a weekly benefit for a period up to 26 weeks of disability due to pregnancy or a non-work related illness or injury. Included in the premium cost is $30,000 Accidental Death and Dismemberment coverage.

Benefits begin on the first day of disability if hospitalized (inpatient) for a minimum of 24 hours, otherwise benefits begin on the 31st day of disability. Preexisting condition limitations may apply during the first six months of plan participation.

Your monthly cost is $0.84 per $100 of your monthly base salary, deducted on an after-tax basis from your paycheck.

You may choose one of the following coverage options, as long as the maximum weekly benefit does not exceed 70% of your actual weekly salary:

- Option A: Maximum weekly benefit of $750 (annual base pay up to $55,714).
- Option B: Maximum weekly benefit of $1500 (annual base pay of $55,715 to $111,429).
- Option C: Maximum weekly benefit of $2000 (annual base pay of $111,430 to $148,571).

SHORT-TERM DISABILITY INSURANCE COMPARISON

UnumProvident	Standard Insurance
Policy # W212	Group ID # 617950
• Cost: $.84 per $100 of salary; After-tax deduction. Benefits are tax-free. Includes $30,000 Accidental Death & Dismemberment Coverage • Pays 70% of base pay up to maximum weekly benefit of $750 (Option A – maximum salary of $55,714), $1,500 (Option B – maximum salary $55,714 to $111,429) or $2,000 (Option C – maximum salary of $111,430 to $148,571) • Benefits begin on the first day if hospitalized for at least 24 hours • Benefits begin on the 31st day if not admitted to hospital • Maximum Payment: 26 weeks • Pre-existing Condition Exclusion: In effect during first 6 months if employee received treatment in the 90 days prior to enrollment • Temporary Recovery (counts as one benefit period unless separated by 6 months of full-time employment) • Pregnancy: Benefits start Day 1 if hospitalized 24 hours; pays 6 weeks for normal birth, 8 weeks for C-section • Does not cover work related injury/illness	• Cost: $.87 per $100 of salary; After-tax deduction; Benefits are tax-free • Pays 66$^{2/3}$% of base pay up to maximum weekly benefit of $769.23 (maximum salary of $60,000) • Benefits begin on the first day if disability is due to an accident • Benefits begin on the 31st day for illness/childbirth * • Maximum Payment: 26 weeks • Pre-Existing Condition Exclusion: no exclusion for new hires. **If late enrollee: benefits begin 61st day if disability is due to illness/childbirth during 1st year of enrollment* • Temporary Recovery (14 days) • Pregnancy: Pays from 31st day through 42nd day after birth for normal delivery. Pays from 31st day through 56th day if C-Section, limitation apply based on job description. • Return to work: partial benefits if working less than 80% time • Does not cover work related injury/illness

LONG-TERM DISABILITY (LTD) INSURANCE

As a retirement-eligible employee, you are automatically enrolled in one of the State's two mandatory LTD programs, starting on your first day of work. The retirement system to which you contribute determines the LTD program available to you.

Your LTD benefit will pay up to 66⅔% of your monthly income during your disability. Your benefits may be subject to an offset based on Social Security payments, retirement benefits and other disability benefits. LTD benefits will end as determined by the plan document provisions. Medical documentation of your disability is required to continue your payment of benefits.

If you are facing a possible long-term disability, you should contact your Human Resources Office within 60 days from the date of your illness or injury for the information you need to apply for LTD benefits.

Standard Insurance Company
Standard Insurance administers the LTD plan for: Optional Retirement Plan (ORP), the Public Safety Personnel Retirement System (PSPRS), the Corrections Officer Retirement Plan (CORP), and the Elected Officials' Retirement Plan (EORP).

Note: Medical residents and federal employees not covered by a State of Arizona retirement plan also participate in the Standard LTD plan.

VPA, Inc.

VPA, Inc. administers the LTD plan for the Arizona State Retirement System (ASRS): You may learn more about the plan by visiting: www.asrs.state.az.us or calling 602.240.2009 or 800.621.3788 if outside of Phoenix.

TheStandard℠
Positively different.

LIFE & DISABILITY INSURANCE

For 12 years, Standard Insurance Company has helped State of Arizona employees safeguard themselves and their loved ones against unexpected loss. Additional Life and Voluntary Short Term Disability insurance from The Standard offers an affordable way to increase your level of protection. At The Standard, we do more than just provide insurance to State of Arizona employees. We help inspire confidence, knowing that someone is there when you need them most.

www.standard.com/mybenefits/arizona 866.440.4846

FLEXIBLE SPENDING ACCOUNTS (FSA)

You have the option to participate in a Health Care and/or Dependent Care Flexible Spending Account administered by ASI.

- The plan year for FSA is January 1 through December 31.
- Your elections from the prior year do not carry over to the new plan year.
- You must enroll every year.
- University Flexible Spending Accounts Open Enrollment is generally held in November of each year. Elections become effective the following January 1.
- You specify the dollar amount of your earnings to be deposited into each account each pay period.
- The amount is deducted from your check before taxes are taken out, lowering your taxable income and your taxes.
- Throughout the year, after you incur an eligible expense, you submit a claim form and your invoices to ASI for reimbursement.
- You must file claims for expenses that you incurred during the plan year no later than March 31 following the end of the plan year.
- ASI reimburses you from the money you have set aside in your Flexible Spending Accounts.
- ASI offers direct deposit for your reimbursement and email notification of payment.
- You may sign up for direct deposit during your initial eligibility or Open Enrollment; the request form is available at www.asiflex.com. If you wish to start direct deposit at any other time, you must contact ASI Customer Service.
- You may also have your statements sent to you by email. Go to www.asiflex.com and follow the links to sign up.
- Contact ASI if you have questions or problems submitting a claim.

Use it or Lose it!

It is important to set aside only as much money in your Flexible Spending Accounts as you intend to use each plan year. IRS regulations require that all money contributed to your Flexible Spending Accounts must be used to pay for expenses incurred (when the services are provided, not when billed or paid) during that plan year only. Otherwise your money is forfeited. Estimate carefully!

Note: When enrolling for a partial Plan year (from your effective date through December 31) remember to include only reimbursable expenses for that period.

Flexible Spending Accounts Life Events/Mid-Year Changes

You cannot change your elections to your Health Care and/or Dependent Care Flexible Spending Accounts after enrollment unless you have a Qualified Life Event as defined by the IRS that causes you, your spouse, or a dependent to gain or lose coverage. The requested change must correspond with the gain or loss of coverage and must be submitted in writing within 31 days of the event.

Tax Credit

There are additional IRS rules that apply to your Dependent Care Flexible Spending Account contributions. You may be eligible to claim the dependent care tax credit on your Federal income tax return. You may want to consult a tax advisor to determine whether participating in the Dependent Care Flexible Spending Account or taking the dependent care tax credit gives you the greater advantage.

Using Your Flexible Spending Accounts

You have several options for obtaining and filing a claim against your Flexible Spending Account. You may obtain a claim form in the following ways:

- On the web - You may download a claim form at www.asiflex.com.
- On the phone - You may call ASI at 1.800.659.3035 and request a claim form.
- By mail - You may request a claim form by sending a written request to: P.O. Box 6044, Columbia, MO 65205.

You will need to fill out your claim form and attach copies of invoices for services you received. Mail the claim form to the address shown above and wait to receive your reimbursement by direct deposit or check.

MEDICAL AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

	HEALTH CARE	DEPENDENT CARE
Maximum Contributions	$5,000 annually	$5,000 annually ($2,500 if married and filing separately)
Use of the Account	* To pay (with pretax money) for health-related expenses that are not covered or only partially covered by your health plans, including expenses for your spouse or children not enrolled in your medical, dental, or vision plans. * To pay for over-the-counter medications that will be used to treat an existing or imminent condition	* Expenses for care, of an eligible dependent, that is provided inside or outside your home. * Care provided for your children under the age of 13 for whom you have custody, for a physically or mentally handicapped spouse or other dependents who spend at least eight hours a day in your home * Dependent care provided so that you can work
Samples of Eligible Expenses	* Copayments * Deductibles * Charges above reasonable and customary limits * Dental fees * Eyeglasses, exam fees, contact lenses and solution, Lasik surgery * Orthodontia * Nonprescription medications (e.g., cold medicines, allergy medicines, antacids, pain relievers)	* Services provided by a day care facility. Must be licensed if the facility cares for six or more children * Babysitting services while you work * Practical nursing care * After school care * Preschool
What's Not Covered	* All insurance premiums * Items not eligible for health care tax exemptions by IRS (e.g., cosmetic surgery) * Long-term care expenses	* Private school tuition including kindergarten * Overnight camp expense * Babysitting when you are not working * Transportation and other separately billed charges * Residential nursing home care
Restrictions/Other Information	* See IRS Publication 502 (expenses in this plan qualify based on when the services are provided regardless of when you pay for the expense) or go to ASI's web site at www.asiflex.com for specific details on what expenses are allowed * You cannot transfer money from one account to the other * Your election amount may be increased (but not decreased) if you have a Qualified Life Event	* See IRS Publication 503 (expenses in this plan qualify based on when the services are provided regardless of when you pay for the expense) or go to ASI's web site at www.asiflex.com for specific details on what expenses are allowed * You may not use the account to pay your spouse, your child who is under age 19 or a person whom you could claim as a dependent for tax purposes * You cannot change your election unless you have a Qualified Life Event

COBRA CONTINUATION OF COVERAGE NOTICE

Federal law requires that most group health plans give employees and their families the opportunity to continue their group health coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan and the covered employee's spouse and dependent children enrolled in the group health plan. (Certain newborns, newly adopted children, and alternative recipients under Qualified Medical Child Support Orders QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

COBRA coverage is the same coverage that the State of Arizona group health insurance plans

(collectively, the "Plan") give to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and HIPAA special enrollment rights.

COBRA applies only to medical, dental, and vision coverages offered by the State of Arizona (the "State") and to Flexible Spending Accounts (FSA) offered by the universities through ASI and not to any other benefits such as life insurance, disability, or accidental death and dismemberment. The Plan provides no greater COBRA rights than what COBRA requires.

Electing Coverage

To elect COBRA medical, dental, or vision coverage, you must complete the Election Form according to the directions on the Election Form and mail or deliver by the date specified to the ADOA Benefits Office. To elect the COBRA Healthcare Flexible Spending Account, complete the enrollment form you will receive from ASI and return by the specified date directly to ASI. Each qualified beneficiary has a separate right to elect COBRA coverage. For example, the employee's spouse may elect COBRA coverage even if the employee does not. COBRA coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect COBRA coverage on behalf of any dependent children. The employee or the employee's spouse can elect COBRA coverage on behalf of all of the qualified beneficiaries.

You may elect COBRA under the group health coverages (medical, dental, vision and health care FSA) in which you were covered under the Plan on the day before the qualifying event. Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under another group health plan (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

Electing Health Care Flexible Spending

COBRA coverage under the Health Care FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected under the Health Care FSA by the covered employee, reduced by reimbursements of expenses incurred up to the time of the qualifying event, is equal to or more than the amount of premiums for Health Care FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage for the Health Care FSA, if elected, will consist of the Health Care FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and COBRA coverage will terminate at the end of the plan year. All qualified beneficiaries who were covered under the Health Care FSA will be covered together for Health Care FSA COBRA coverage. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate Health Care FSA annual

coverage limit and a separate COBRA premium. If you are interested in this alternative, contact the ADOA Benefits Office.

Special Considerations

In considering whether to elect COBRA coverage, you should take into account that a failure to elect COBRA will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of COBRA coverage may help you not have such a gap. Second, you may lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get COBRA coverage for the maximum time available to you. Finally, you should take into account that you may have special enrollment rights under federal law. You may have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends because of the Qualifying Life Event listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

COBRA Duration

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage under the Plan as a result of the qualifying event can last up to 36 months from the date of Medicare entitlement. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months before the termination of employment or reduction of hours.

In the case of a loss of coverage due to an employee's death, divorce or legal separation, or a dependent child ceasing to be a dependent under the terms of the Plan, COBRA coverage may be continued for up to a total of 36 months.

Regardless of the qualifying event, health care FSA COBRA coverage may only be continued to the end of the plan year in which the qualifying event occurred and cannot be extended for any reason.

This notice shows the maximum period of COBRA coverage available to qualified beneficiaries.

COBRA coverage will automatically terminate before the end of the maximum period if:

- A required premium is not paid-in-full on time,
- A qualified beneficiary becomes covered, after electing COBRA coverage under another group health plan (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied),

- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA coverage,
- The State ceases to provide any group health plan for its employees; or
- During a disability extension period (the disability extension is explained on page 46), the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled.

COBRA coverage may also be terminated for any reason (for example, the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage as in a case of fraud). You must notify the applicable carrier(s) in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B or both) or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied). COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any applicable preexisting condition exclusion). The claims administrators, insurance carriers and/or HMOs may require repayment of all benefits paid after the termination date, regardless of whether or when you provide notice of Medicare entitlement or other group health plan coverage.

Extension of COBRA Period

If you elect COBRA coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is or becomes disabled or a second qualifying event occurs. You must notify the applicable carriers in writing of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will affect the right to extend the period of COBRA coverage. (The period of COBRA for a Flexible Spending Account cannot be extended beyond the end of the current Plan year under any circumstances).

Disability

If any of the qualified beneficiaries is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from the covered employee's termination of employment or reduction of hours (generally 18 months as described above) may be extended up to a total of 29 months. The disability must have started at some time before the 61st day of COBRA coverage obtained due to the covered employee's termination of employment or reduction of hours with the State and must last until the end of the 18-month period of COBRA coverage. Each qualified beneficiary who has elected COBRA coverage will be entitled to the disability extension if one of them qualified. The disability extension is available only if you notify the applicable carrier(s) (see "For More Information" section below) in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- The date of the Social Security Administration's disability determination
- The date of the covered employee's termination of employment or reduction of hours, or

- The date of which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination or reduction of hours

You must also provide this notice within the original 18 months of COBRA coverage obtained due to the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. The notice must be provided in writing and must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event
- The name and address of the disabled qualified beneficiary
- The date that the qualified beneficiary became disabled
- The date that the Social Security Administration made its determination of disability
- A statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled, and
- The signature, name and contract information of the individual sending the notice

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail this notice within the required time periods to the ADOA Benefits Office (see "For More Information" on page 39).

If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no disability extension of COBRA coverage.

If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the applicable carrier(s) of that fact within 30 days after the Social Security Administration's determination. COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the Social Security Administration's determination. COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. The notice must be provided in the same manner as, and include the same information required for, a notice of disability as described above.

Second Qualifying Event

An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the first 18 months (or, in the case of a disability extension, the first 29 months) of COBRA coverage following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the date COBRA coverage began. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan.

This extension due to a second qualifying event is available only if you notify the applicable carrier(s) (see "For More Information" section on page 39) in writing of the second qualifying event within 60 days after the date of the second qualifying event.

The notice must include the following information:

- Name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event
- Nature of the second qualifying event
- Date of the second qualifying event
- Signature, name and contact information of the individual sending the notice

In addition, you must provide documentation supporting the occurrence of the second qualifying event, if the ADOA Benefits Office requests it. Acceptable documentation includes a copy of the divorce decree, death certificate, or dependent child(ren)'s birth certificates, driver's license, marriage license or letter from a university or institution indicating a change in student status.

You must mail this notice within the required time periods to the ADOA Benefits Office .

If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

COBRA Cost

Generally, each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage.

When and How To Pay for Coverage

If you elect COBRA coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage no later than 45 days after the date of your election. (This is the date the Election Form is post-marked, if mailed, or the date your Election Form is received by the individual at the address specified for delivery on the Election Form, if hand delivered.) If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is correct.

After you make your first payment for COBRA coverage, you will be required to make

monthly payments for each subsequent month of COBRA coverage. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. The Plan will send periodic notices of payments due for these coverage periods (that is, you will receive a bill for your COBRA coverage – it is your responsibility to pay your COBRA premiums on time. If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each payment for that month. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

All COBRA premiums must be paid by check or money order. Payments must be made payable to the applicable carriers for which you are electing coverage:

- UnitedHealthcare for either UHC EPO or UHC PPO
- Fiserv Health - Harrington for any of the following plans: Arizona Foundation PPO, Beech Street PPO, RAN+AMN EPO or Schaller Anderson EPO.
- Delta, MetLife, EDS or Assurant for dental premiums
- Avesis for vision premiums
- ASI for the Healthcare Flexible Spending Account

Your first payment should be mailed to: ADOA Benefits Office 100 N. 15th Avenue, Ste. 103 Phoenix, AZ 85007. After the initial payment, you will receive an invoice each month that will include the applicable Plan Administrator or carrier address.

Note: All COBRA payments for BCBS (NAU only) should be made payable to NAU and mailed to NAU Human Resources PO Box 4113 Flagstaff, AZ 86011-4113.

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand delivered, your payment is considered to have been made when it is received. You will not be considered to have made any payment if your check is returned due to insufficient funds or otherwise.

More information about individuals who may be qualified beneficiaries
A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for

himself or herself and enrolls the child within 30 days of the birth, adoption or placement for adoption. To be enrolled in the Plan, the child must satisfy the otherwise applicable eligibility requirements (for example, regarding age).

A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the university during the covered employee's period of employment is entitled to the same rights to elect COBRA as any other eligible dependent child of the covered employee.

For More Information
This notice does not fully describe COBRA coverage or other rights under the Plan. More information about COBRA coverage and your rights under the Plan is available from your Human Resources Office.

Address Changes
In order to protect you and your family's rights, it is important that you keep your Human Resources Office informed of any changes in your address and the addresses of family members.

ADDITIONAL BENEFITS

This information regarding additional benefits is a overview of benefits provided by all three universities. Please reference your individual university's website or consult with your Human Resources Office for your university's specifics.

Supplemental Retirement Savings
Tax Sheltered Annuity IRS Tax Code 403(b)
This type of plan offers the opportunity for you to defer tax on a portion of earnings by purchasing traditional annuity or mutual fund products through the university's approved vendors.

Deferred Compensation Plan IRS Tax Code 457
A plan administered by Nationwide Retirement Solutions allowing you to defer a pre-tax portion of earnings into a supplemental retirement account.

Leave Policies
Bereavement Leave
You are allowed up to three days of leave for bereavement and funeral purposes of covered family members. For out-of-state funerals the leave increases to five days. You may use sick leave upon the death of family members not covered under the bereavement policy.

Family and Medical Leave (FML)
FML provides for up to 12 work weeks of leave during a designated "leave year" for a qualifying reason. You must have at least 12 months of cumulative service and have worked at least 1,250 hours at the university during the 12-month period preceding the date FML is to begin.

FML may apply to continuous, intermittent, or reduced schedule absences. The leave requires the use of accrued sick leave, and permits use of accrued vacation; otherwise, FML is unpaid.

FML qualifying reasons:

- The birth and care of a child;
- The adoption or foster care of a child;
- The care of your spouse, child or parent who has a serious health condition;
- Your own serious health condition that prevents you from performing the essential functions of your position.

Holiday Pay
Regular Classified Staff, Service Professionals and Administrative employees shall be granted time off from work with pay for each holiday designated by the university. Ten holidays are normally designated each year.

Employees shall be paid on a prorated basis for designated holidays based upon their regularly scheduled total pay period hours.

Jury Duty
Employees called upon for service on a jury or as a subpoenaed witness, other than as a plaintiff or defendant, in a judicial or administrative proceeding, shall be granted leave with pay to perform such service.
An employee who receives a fee for jury duty or as a subpoenaed witness shall either:

- Remit the jury/witness fee to the university and record the time off as administrative paid leave, or
- Accept jury duty fees and record jury duty hours using the appropriate paid or unpaid leave.

Military Leave
Employees who are members of the National Guard or a reserve component of the U. S. Armed Forces shall be granted leave with pay for active duty or active duty training for a period not to exceed 30 work days in any two consecutive calendar years.

Employees who are voluntarily or involuntarily placed on extended active duty with the National Guard or the U.S. Armed Forces shall be placed on a leave without pay status in a manner consistent with applicable Arizona Revised Statutes and the Federal Veterans Reemployment Act. Extended active duty is defined as a period of more than 30 calendar days.

Sick Leave
Eligible full-time employees accrue sick leave at the rate of 12 days per year; if you are less than full-time, the accrual rate is prorated. Employees accrue and may use sick hours during initial probation. You may be granted sick leave for:

- Personal illness, injury or pregnancy/childbirth
- Obtaining health-related services
- Serious illness/injury within your immediate family or established household.

Sick leave may be accumulated without limitation. Accumulated hours are paid out at retirement (not resignation) according to an established schedule. The Retiree Accumulated Sick Leave program is administered by the State of Arizona GAO. Retirees must qualify and apply for this benefit.

An employee hired from another Tri-U university or a State of Arizona agency within 30 days of termination may have unused accumulated sick leave transferred. An employee rehired by a university within 12 months after termination is credited with all unused sick leave accumulated at the time of termination.

Unpaid Leaves
Unpaid leaves of up to one year may be granted by the responsible administrator or supervisor.

Vacation Leave
The annual accrual rate for full-time classified staff is:

- First and 2nd years, 11 days per year
- 3rd and 4th years, 16 days per year
- 5th year and beyond, 22 days per year

Vacation hours are accrued on a pay period basis. If you are less than full-time, the accrual rate is prorated.

Administrative, Professional and fiscal-year Faculty employees are entitled to 22 days of vacation each year. Faculty members on academic year appointments are not eligible for vacation leave.

Qualified In-State Tuition Reduction Program
The Arizona Board of Regents provides a Qualified Tuition Reduction (QTR) program that enables employees and retirees, their spouses and dependents to enroll in courses of study at reduced registration fees. The QTR is reciprocal among the three state universities and may be used for spring, fall, winter or summer sessions.

Workers' Compensation
All employees are insured and are provided benefits under the Workers' Compensation Act in the event of a job-related injury or illness. Benefits include medical expenses, compensation for lost work time, permanent disability benefits and death benefits as applicable.

Absence from work due to an on-the-job injury or illness is considered to be a serious health condition for the purposes of applying Family and Medical Leave. If you are eligible for and entitled to FML, the time away from work while you are covered under Workers' Compensation will be credited to your FML entitlement.

GLOSSARY OF TERMS

Actively at Work
The plan provision that requires you to be performing the duties of your occupation in order for coverage to commence. If you are absent due to illness or injury, the coverage doesn't commence until you return to active work status. You are considered actively at work on a paid vacation day or established holiday if you were actively at work on the preceding scheduled work day.

Coinsurance
The division of the allowed amount to be paid on a claim, i.e. 70/30 means 70% is to be paid by insurance and 30% is paid by you.

Coordination of Benefits
A process used to determine payment of a claim when you are covered under more than one group plan. Benefits under the plans are limited to no more than 100 percent of the claim.

Co-payment
The established fee that must be paid to a provider at the time services are rendered.

Deductible
The initial amount on a PPO plan you must pay out of pocket before benefits are paid by your insurance.

Emergency
Defined by each plan in the Plan Description.

Exclusive Provider Organization (EPO)
A prepaid medical group plan that provides a predetermined medical care benefit package.

In-Network
Services performed by a provider contracted with a network in accordance with all plan requirements.

Indemnity Plan
A health care plan that allows you to choose any licensed provider to receive care. Members are reimbursed for eligible reasonable and customary health care expenses according to the benefits schedule which includes a deductible and coinsurance.

Medically Necessary
Services or supplies provided to identify or treat an illness or injury. Services and supplies must be given in accordance with proper medical practice prevailing in the medical specialty or field at the time the patient received the service or in the least costly setting required for the patient's condition. The service must be consistent with the patient's illness, injury or condition and be required for reasons other than the patient's convenience. The fact that a physician prescribes a service or supply does not necessarily mean it is medically necessary.

Out-of-Network
Services performed by a provider that is not contracted with a network.

Plan Year
October 1 through September 30 for medical, dental and vision plans. January 1 through December 31 for Flexible Spending Account plans.

Pre-Existing Condition
A condition diagnosed and/or treated prior to the effective date of coverage or one for which a prudent person would have been treated.

Preferred Provider Organization (PPO)
A plan that allows a member to choose either a provider of their choice or a provider contracted with the network. Choosing an in-network provider will result in a higher percentage of the cost of services being covered.

Premium
The amount you and your employer pay for insurance coverage.

Prescription Drugs
Any drug or medication that requires a physician order.

Generic Drug
A generic drug is one approved by the U.S. Food and Drug Administration (FDA) that is chemically identical to its brand-name equivalent. To win FDA approval, the generic drug must contain the same amounts of the same active ingredients as its brand-name equivalent. A generic drug typically is less expensive and is sold under a generic name for that drug (usually its chemical name). Because generic drugs are less expensive than their brand-name equivalent, your co-payment usually is less, as well.

Preferred (Formulary) Drug
All preferred brand drugs have received FDA approval as safe and effective, and have been chosen by a committee of physicians and pharmacists.

Non-Preferred (Non-Formulary) Drug
A medication that does not appear on the preferred or generic drug list and carries a higher co-payment.

Reasonable and Customary Charges
The prevailing charge made by physicians, dentists, or other service providers for a similar procedure in a particular geographic area.

Self-Insured Plan
A self-insured plan is one in which the employer assumes the direct financial responsibility for the costs of health insurance claims. Employers sponsoring self-insured plans typically contract with an insurance carrier (i.e. UnitedHealthcare) or third party administrator (i.e. Fiserv Health - Harrington) to provide administrative services.

NOTICE OF THE ARIZONA BENEFIT OPTIONS PROGRAM PRIVACY PRACTICES

The administrators of Arizona Benefit Options know that the privacy of your personal information is important to you. This Notice describes how medical information about you may be used and disclosed, how you may gain access to this information, and the measures taken to safeguard your information. Throughout this Notice, all references to Arizona Benefit Options refer to the administrators of the Program. Please review it carefully.

USE AND DISCLOSURE OF HEALTH INFORMATION

Arizona Benefit Options may use your health information for purposes of making or obtaining payment for your care, and for conducting health care operations. Arizona Benefit Options has established a policy to guard against unnecessary disclosure of your health information. For purposes of this Notice, health information refers to any information that is considered protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act ("HIPAA") of 1996.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

To Make or Obtain Payment Arizona Benefit Options may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, Arizona Benefit Options may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations Arizona Benefit Options may use or disclose health information for its own operations to facilitate the administration of Arizona Benefit Options and as necessary to provide coverage and services to all Arizona Benefit Options' participants. Health care operations include activities such as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Reviews and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning analyses and formulary development. In addition, summary health information may be provided to third parties in connection with the soliciation of health plans or the modification or amendment of the existing plan.

As an example, Arizona Benefit Options may use your health information to conduct case management, quality improvement and utilization review, and provider credentialing activities or to engage in customer service and grievance resolution activities.

For Treatment Alternatives Arizona Benefit Options may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services Arizona Benefit Options may use or disclose your health information to provide you with information on health-related benefits and services that may be of interest to you.

When Legally Required Arizona Benefit Options will disclose your health information when it is required to do so by any federal, state or local law.

To Conduct Health Oversight Activities Arizona Benefit Options may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. Arizona Benefit Options, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings As permitted or required by state law, Arizona Benefit Options may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when Arizona Benefit Options makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes As permitted or required by state law, Arizona Benefit Options may disclose your health information to a law enforcement official for certain law enforcement purposes, including but not limited to if Arizona Benefit Options has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

In The Event of a Serious Threat to Health or Safety Arizona Benefit Options may, consistent with applicable law and ethical standards of conduct, disclose your health information if Arizona Benefit Options, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health and safety or to the health and safety of the public.

For Specified Government Functions In certain circumstances, federal regulations require Arizona Benefit Options to use or disclose your health information to facilitate specific government functions related to the military and veterans, to national security and intelligence activities, to protective services for the president and others, and to correctional institutions and inmates.

For Workers Compensation Arizona Benefit Options may release your health information to the extent necessary to comply with laws related to workers compensation or similar programs.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, Arizona Benefit Options will not disclose your health information without your written authorization. If you authorize Arizona Benefit Options to use or disclose your health information, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that Arizona Benefit Options maintains:

Right to Request Restrictions You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on Arizona Benefit Options' disclosure of your health information to someone involved in the payment of your care. However, Arizona Benefit Options is not required to agree to your request.

Right to Receive Confidential Communications To safeguard the confidentiality of your health information, you may request that Arizona Benefit Options communicate in a specified manner or at a specified location. Alternatively, for example, you may request that all health information be mailed to your work location rather than your home. If you wish to receive confidential communications, please make your request in writing. Arizona Benefit Options will accommodate reasonable requests, when possible.

Right to Inspect and Copy Your Health Information You have the right to inspect and copy your health information. If you request a copy of your health information, Arizona Benefit Options may charge a reasonable fee for copying, assembling costs and, if applicable, postage associated with your request.

Right to Amend Your Health Information If you believe that your health information records are inaccurate or incomplete, you may request that Arizona Benefit Options amend the records. That request may be made as long as the information is maintained by Arizona Benefit Options. Arizona Benefit Options may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by Arizona Benefit Options, if the health information you are requesting to amend is not part of Arizona Benefit Options' records, if the health information you with to amend falls within an exception to the health information you are permitted to inspect and copy, or if Arizona Benefit Options determines the records containing your health information are accurate and complete.

Right to an Accounting You have the right to request a list of disclosures of your health information made by Arizona Benefit Options for any reason other than for treatment, payment or health operations. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. Arizona Benefit Options will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. Arizona Benefit Options will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically.

DUTIES OF ARIZONA BENEFIT OPTIONS

Arizona Benefit Options is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. Arizona Benefit Options is required to abide by the terms of this Notice, which may be amended from time to time. Arizona Benefit Options reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If Arizona Benefit Options changes its policies and procedures, Arizona Benefit Options will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to Arizona Benefit Options and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Arizona Benefit Options encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT INFORMATION

For more information or for further explanation of this document, you may contact an Arizona Benefit Options representative at 602.542.5008 (outside the Phoenix area, toll free at 1.800.304.3687), or by email at beneissues@azdoa.gov. You may also obtain a copy of this Notice at our web site at www.benefitoptions.az.gov. The ADOA Privacy Officer may be contacted at 100 N. 15th Avenue, Suite 401, Phoenix, Arizona 85007.

EFFECTIVE DATE

This Notice is effective April 14, 2003.